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No. 92-881

In The
Supreme Court of the United States
October Term, 1992

JAMES MAXA AS PERSONAL REPRESENTATIVE
FOR THE ESTATE OF NEIL MAXA,

Petitioner,

vs.

JOHN ALDEN LIFE INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to The United States Court of Appeals for the Eighth Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether the Court below correctly decided that Petitioner, in seeking to recover health benefits on allegations of a faulty summary plan description governed by ERISA 29 U.S.C. § 1001, *et seq.*, had to establish detrimental reliance on the plan summary.

PARTIES

Petitioner is James Maxa, as personal representative for the estate of Neil Maxa.

Respondent is John Alden Life Insurance Company, whose immediate parent is Houston National Life Insurance Company, which in turn, is wholly owned by John Alden Financial Corporation. John Alden Life Insurance Company has no subsidiaries other than wholly-owned subsidiaries, except for the Preferred Management Life Insurance Company.

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RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent, John Alden Life Insurance Company ("John Alden"), submits this brief in opposition to Petitioner James Maxa's request that this Court issue a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

STATEMENT OF THE CASE

This action involves a claim for medical benefits under a group health plan insured through John Alden and governed by ERISA, 29 U.S.C. § 1001, *et seq.*

In July 1984, Neil Maxa, the president of H.R. Peterson Co., Inc., ("H.R. Peterson"), completed a request for participation in a group health benefit plan insured through John Alden. H.R. Peterson was accepted as a participating employer in the group health plan and, subsequently, Neil Maxa and his spouse were provided group health coverage as employees of H.R. Peterson. Neil Maxa was 62 years old when he enrolled for coverage with John Alden.

At the time Neil Maxa became an insured under John Alden's group health plan, he received a certificate of group insurance setting forth his rights and obligations under the plan. This group health certificate contained a coordination of benefits provision which reads, in pertinent part, as follows:

> We [John Alden] will coordinate your medical and dental benefits (if applicable) with benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental care or treatment through:
>
> (1) Group, blanket or franchise insurance (other than school accident policies);
>
> (2) Group hospital or medical service organizations, group practice, or other prepayment coverage on a group basis;

(3) A labor management trustee plan, union welfare plan, employer or employee benefit plan, or other arrangement of benefits for individuals of a group;

(4) Medicare (Parts A & B) when you are eligible for medicare coverage. For purposes of determining your Medicare benefits, you will be deemed to have enrolled for all coverages for which you are eligible under Medicare (Parts A & B), whether or not you actually enroll.

Coordination means that benefits are paid so that no more than 100% of your necessary, reasonable, and customary expenses will be covered under the combined benefits of all plans.

When Neil Maxa attained the age of 65, his insurance premium was reduced from $210 to $134.90. Neil Maxa failed to make application for either Medicare Part A or Medicare Part B before he died in June 1989, at the age of 68. At the time of his death, a number of medical bills remained outstanding. John Alden made its share of payments to various medical providers after coordinating benefits with Medicare. Because Neil Maxa failed to enroll in Medicare, various medical bills remained outstanding. John Alden declined James Maxa's requests, on behalf of Neil Maxa's estate, that it forego coordinating Neil Maxa's group health benefits with Medicare, and this litigation ensued.

On July 17, 1990, James Maxa filed this action in the Federal District Court for the District of Minnesota, alleging jurisdiction under 29 U.S.C. § 1132(a)(1). In his Complaint, James Maxa alleged, among other things, that the estate was entitled to medical benefits because the summary plan description was inadequate and in violation of § 102(a)(1) of ERISA, 29 U.S.C. 1022(a)(1).

On March 1, 1991, James Maxa and John Alden made cross motions for summary judgment. In a Memorandum and Order dated April 17, 1991, the Honorable Paul A. Magnuson, denied James Maxa's motion for summary judgment and granted John Alden's cross-motion for summary judgment and dismissed James Maxa's case. On May 16, 1991, James Maxa appealed from the judgment entered pursuant to Judge Magnuson's Memorandum and Order dated April 17, 1991. On August 17, 1992, the United States Court of Appeals, Eighth Circuit, affirmed the District Court's grant of summary judgment in favor of John Alden. Maxa v. John Alden Life Insurance Company, 972 F.2d 980 (8th Cir. 1992).

ARGUMENT

I. THE QUESTION PRESENTED WAS CORRECTLY DECIDED BELOW IN ACCORDANCE WITH WELL AND WIDELY-ESTABLISHED PRECEDENT.

Petitioner ("James Maxa") seeks to eliminate the element of detrimental reliance from a claim for welfare benefits premised upon a faulty ERISA plan summary. In essence, Petitioner requests a ruling that insurers of ERISA welfare benefit plans are strictly liable for claimed benefits solely upon a showing that the plan summary failed to meet the requirements of ERISA and its attendant regulations. In other words, James Maxa seeks to be relieved of the responsibility of establishing that the alleged faulty plan summary in any way caused the harm for which benefits are being sought.

In the instant case, James Maxa has established no nexus between the harm caused by Neil Maxa's failure to enroll in Medicare and the purportedly faulty summary plan description. Without establishing such a nexus, James Maxa has proved nothing more than that the estate suffered a loss because of Neil Maxa's failure to enroll in Medicare. James Maxa's attempt to be relieved of the responsibility of showing some causal relation between what he alleges to have been wrong with the summary plan and the harm suffered by the estate would convert ERISA into a form of strict liability law.

The Court of Appeals and the District Court, citing a long and consistent line of authority from the Eighth Circuit,

rejected the petitioner's argument. (A. 16-17 and A. 4-5.) The requirement that a plaintiff establish that he took action, resulting in some detriment, that he would not have taken had he known the terms of the plan were otherwise, has been a long-established element of a claim for relief on the basis of a faulty plan summary. Anderson v. Alpha Portland Industries, Inc., 836 F.2d 1512, 1520 (8th Cir. 1988); Lee v. Union Electric Co., 789 F.2d 1303, 1308 (8th Cir.) *cert. denied*, 479 U.S. 962 (1986); Monson v. Century Mfg. Co., 739 F.2d 1293, 1302 (8th Cir. 1984). In some instances, detrimental reliance by plan participants can be inferred from the nature and manner of representations made regarding the terms of the plan. Monson v. Century Mfg. Co., 739 F.2d 1293, 1302 (8th Cir. 1984). In this case, however, detrimental reliance could not be inferred as the plan summary, while arguably not as clear as it could have been, "enabled a reasonable participant to conclude that the he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits, and, at the very least, did not suggest to a reasonable reader that there was no reason to apply for Medicare." (A.17)

The conversion of ERISA into a strict liability statute has been rejected by the courts. The Eleventh Circuit, in another case in which an estate sought medical benefits based upon a faulty summary plan description, specifically rejected a strict liability standard for such claims. Branch v. G. Bernd Co., 955 F.2d 1574, 1578 (11th Cir. 1992). The element of detrimental reliance has been consistently applied in nearly all the federal circuits considering the issue. The

First and Third Circuits have held that beneficiaries who seek to enforce the terms of a faulty summary plan must show reliance on the summary. Bachelder v. Communications Satellite Corp., 837 F.2d 519, 522-23 (1st Cir. 1988) ("appellees cannot recover. . .because appellees did not show significant reliance or even the possibility of prejudice flowing from the [summary]"); Govoni v. Bricklayers, Masons, and Plasters Int'l Union Local No. 5 Pension Fund, 732 F.2d 250, 252 (1st Cir. 1984) ("[c]ase law suggests . . . that to secure relief, Govoni must show some significant reliance on, or possible prejudice flowing from, the faulty plan description"); Gridley v. Cleveland Pneumatic Co., 924 F.2d 1310, 1319 n.8 (3d Cir.), *cert. denied*, ___ U.S. ___, 111 S. Ct. 2856, 115 L.Ed.2d 1023 (1991). Similarly, the Fourth and Seventh Circuits also require a showing of reliance. Pierce v. Security Trust Life Ins. Co., 1992 W.L. 214042 (4th Cir. Va.); Black v. TIC Investment Corp., 900 F.2d 112, 115 (7th Cir. 1990).

In fact, only the Sixth Circuit has suggested that a beneficiary need not show reliance to enforce a summary's terms. Edwards v. State Farm Mut. Auto. Ins. Co., 851 F.2d 134 (6th Cir. 1988). In Edwards, the court found that the beneficiary had, in fact, relied upon the summary plan description; consequently, the suggestion that reliance is unnecessary is at best dictum. More importantly, however, Edwards involved a case where the summary plan description, by its terms, provided greater benefits than the plan. Consequently, the issue for the court was whether the terms of the plan, which the employee never received, would

prevail over the terms of the summary. The court concluded that the beneficiary had "been misled" by the summary and, therefore, the employer was unable to enforce the terms of its plan which were inconsistent with the summary. Id. at 136-137. Thus, at a minimum, Edwards stands for the proposition that a participant must at least establish that he or she has "been misled" by the summary. See also, Branch v. G. Bernd Co., 955 F.2d 1574 (11th Cir. 1992) (interpreting Edwards).

The instant case does not involve a claim for benefits based upon a plan summary which is inconsistent with the plan. Instead, petitioner seeks relief on the theory that John Alden's summary did not meet the requirements of ERISA and its attendant regulations. For example, petitioner argues that John Alden's summary does not use "commonly understood words" such as "reduced, diminished, or limited." (Petitioner's Brief at p.6.) The petitioner has not, and cannot, establish that James Maxa was misled by John Alden's summary. The Eighth Circuit, in interpreting John Alden's summary, found that while it was not "crystal clear," the summary could be "reasonably read to imply that benefit coverage will reduce by the amount of Medicare coverage for which one is eligible." (A.16) In other words, John Alden's summary was not misleading. The summary "did not suggest to a reasonable reader that there was no need to apply for Medicare." (A.17). In fact, John Alden's summary "enabled a reasonable participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits." (A.17) Therefore, the Circuit Court

rejected the petitioner's interpretation that John Alden's coordination of benefits provision prohibits only the receipt of duplicative benefits. This rejection was sound as petitioner's interpretation requires one to ignore the very paragraph relating to Medicare coverage. (Paragraph 4 of the "Coordination of Benefits" provision.)

In essence, Petitioner's request of this Court to entertain this case would result only in the Court interpreting a particular summary plan's language for the purpose of determining whether one could reasonably conclude that it was unnecessary to enroll in Medicare. This language has already been interpreted by two courts and a third interpretation is unnecessary and, furthermore, is not important enough to warrant review.

II. THE DECISION BELOW IS NOT INCONSISTENT WITH THIS COURT'S PRECEDENT.

James Maxa argues that the Eighth Circuit's decision in this case is inconsistent with this court's opinion in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989). The argument appears to be that the Eighth Circuit's requirement of reliance results in deference to a participant's interpretation of plan language. Petitioner correctly interprets Bruch to be mean that "courts should not defer 'to either party's interpretation' when construing an ERISA governed plan." (Petitioner's Brief at p.9.) Yet, after providing this analysis of Bruch, petitioner then contends that his interpretation of the plan language should be given deference

under the *contra proferentem* rule of contract construction. (Petitioner's Brief at pp. 9-10.)

Petitioner's argument on this point is internally inconsistent. Moreover, Bruch cannot be read to absolve plan participants or beneficiaries from establishing that they relied to their detriment upon a faulty plan summary. The showing of reliance is an element separate and distinct from the proper interpretation of a plan or summary. The Eighth Circuit correctly acknowledged this Court's instructions in Bruch, and conducted its own *de novo* review. The court, in conducting its review, gave no deference to John Alden's interpretation of the summary nor deferred to petitioner's interpretation. Based upon its independent *de novo* examination, the Court of Appeals determined that, while John Alden's summary may not have met the technical requirements of ERISA, the language could reasonably be read to imply that benefit coverage will be reduced by the amount of Medicare coverage for which one is eligible. (A.16) The Circuit Court's determination that the petitioner had to establish that Neil Maxa relied to his detriment upon the summary's language is an element separate and distinct from the interpretation of the summary. This Court's decision in Bruch provides the lower court with instructions regarding the manner in which they are to construe the language of ERISA plans. This decision, however, cannot be understood to stand for the proposition that once plan language has been interpreted, it is unnecessary for participants or beneficiaries to establish that they relied to their detriment upon an adopted interpretation of the plan.

III. THE APPLICATION OF THE CONTRA PROFERENTEM RULE WOULD NOT CHANGE THE RESULT IN THIS CASE.

While the petitioner styles the question presented as one involving the necessity of reliance for ERISA benefits claims, he also discusses the application of the *contra proferentem* rule to ERISA plans as a justification for review. (Petitioner's Brief at pp. 10-15.) Petitioner claims that had the Eighth Circuit applied the *contra proferentem* rule in this case, the estate would have prevailed. (Petitioner's Brief at p. 14.) Petitioner contends that the Eighth Circuit failed to apply the *contra proferentem* rule because of its prior decision in Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150 (8th Cir. 1990). Petitioner claims that Brewer is in conflict with the decisions of the Second, Seventh and Ninth Circuits. (Petitioner's Brief at p. 10.)

The Eighth Circuit, however, does not reject the use of the *contra proferentem* rule in ERISA cases. In Delk v. Durham Life Ins. Co., 959 F.2d 104 (8th Cir. 1992), the court expressly adopted the use of the principle of *contra proferentem* in construing ambiguous plan language:

> After applying ordinary principles of interpretation to the plan at issue (citation omitted), the district court found the language of the plan ambiguous. When extrinsic evidence failed to resolve the ambiguities in the language, the court construed the language of the plan against Durham. In Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d 150, 153 (8th Cir. 1990), we held that the Missouri rule of construction that requires ambiguities to be construed in favor of the insured cannot be used in interpreting the terms of a

> plan governed by ERISA. There, we were able to resolve the ambiguity in the language by interpreting the language as would "an average plan participant" (citation omitted). The language at issue in Brewer ceased to be ambiguous when it was accorded its ordinary, and not specialized, meaning.
>
> Here, however, as the district court aptly demonstrated, the language remains ambiguous even after the applying the approach in the Brewer. Therefore, the district court correctly used the principle of *contra proferentem* and construed the ambiguous language against Durham. As a matter of federal common law, a court construing plans governed by ERISA should construe ambiguities against the drafter only if, after applying ordinary principles of construction, giving its language ordinary meaning and admitting extrinsic evidence, ambiguities remain.

Id. at 105-106.

In the instant case, the Eighth Circuit found the language of John Alden's summary "enabled a reasonable plan participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits." (A.17) The Eighth Circuit expressly rejected petitioner's argument that the language could suggest "to a reasonable reader that there was no need to apply for Medicare." (A.17) Therefore, the *contra proferentem* would not aid petitioner because its interpretation was unreasonable. This is even more so the case when one considers extrinsic evidence such as that the participant's premiums were reduced from $210 to $134 at the time he attained the age of 65.

Therefore, this is not a situation wherein the court was confronted between choosing two reasonable interpretations based upon an ambiguity in plan language. Petitioner's interpretation was unreasonable. John Alden's summary, although not "crystal clear" and in technical compliance with ERISA, did "enable a reasonable participant to conclude that he or she might have to enroll in Medicare in order to avoid a reduction of overall benefits."

In sum, the Eighth Circuit does not flatly reject the *contra proferentem* rule in ERISA cases and, therefore, the particular conflict that petitioner alludes to does not exist. This case does not present the proper vehicle for the examination of the issue of *contra proferentem* in ERISA litigation.

CONCLUSION

For all the reasons stated above, this court should deny James Maxa's Petition for Writ of Certiorari.

Dated: December 16, 1992

Respectfully submitted,

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